Nevada State Veterans Home
Application for Admission

Section I

PERSONAL INFORMATION

[ ] Veteran [ ] Spouse of Veteran [ ] Parents all of whose children died while serving in the Armed Forces of the United States

Last Name First Middle Alias/Nickname

Social Security # Spiritual Needs (Religion)

Date of Birth Place of Birth

Home Address Street City State Zip

Mailing Address *(If different from above)* Street City State Zip

Home Phone Cell Phone Message Phone

Are you a resident of or did you join the military from Nevada? Yes No
(Initial One)

Are you currently – [ ] Married [ ] Widowed [ ] Never married [ ] Divorced

If married, please answer the following questions:

Spouse's full name Last First Middle

How long have you been married? Is he/she a veteran? [ ] Yes [ ] No

Is he/she also applying for admission to NSVH? [ ] Yes [ ] No Spouse's Social Security #

Are you under guardianship [ ] Yes [ ] No If yes, must send a copy of the guardianship papers.

Guardian's Last Name First Name Middle Initial Relationship

Street City/State Zip Area Code Telephone #

Area Code Telephone #

Emergency Contact *(if different from above)*

1.

Last Name First Name Middle Initial Relationship

Street City/State Zip Area Code Telephone #

Area Code Telephone #

Section I

Emergency Contact (continued)

2.

Last Name | First Name | Middle Initial | Relationship

Street | City/State | Zip | Area Code Telephone #

Area Code Telephone #

Do you have a Financial Power of Attorney? [ ] Yes [ ] No
Do you have a Durable Power of Attorney for Healthcare? [ ] Yes [ ] No
Do you have an Advance Directive/Living Will? [ ] Yes [ ] No
Please provide copies to NSVH

Do you have a Pre-Paid Funeral Plan or Mortuary Preference? [ ] Yes [ ] No

Name/Location

MILITARY SERVICE INFORMATION

What name did you serve under in the military? Last First Middle

Branch of service? Service Number?

Dates of active service? From Until Type of discharge

From Until Type of discharge

Military Occupation Highest rank attained

Are you retired from the military? [ ] Yes [ ] No Were you a prisoner of war? [ ] Yes [ ] No

VETERANS BENEFITS INFORMATION

Have you ever applied for U.S. Department of Veterans Affairs (VA) benefits? [ ]Yes [ ] No

Are you currently enrolled in the VA Health Care System? ? [ ]Yes [ ] No

Do you have a service-connected disability? [ ] Yes [ ] No
If yes, what is your total percentage rating %

Do you receive non-service-connected pension benefits? [ ] Yes [ ] No
If yes, please list

Section I

Comments (add additional sheets if necessary):

I certify that the information provided herein is true and correct to the best of my knowledge and belief.

Print Name

Sign Name

Date

FOR NSVH USE ONLY

Primary Pay Source

Secondary Pay Source

Dental Insurance Coverage

Nevada State Veterans Home **Section II**

Financial Statement

Initial here _____ I understand that as part of my application to the Nevada State Veterans Home, the Nevada Office of Veterans Services of the State of Nevada has the right to investigate my financial affairs and I consent to such an investigation.

Initial here _____ If I am admitted to the Nevada State Veterans Home, I agree to pay the prescribed amount of fees as determined by my personal resources.

Veteran's Name:

I (for self or as financial legal representative for veteran) hereby declare that my total income and assets are as follows:

Per Month Incomes (Gross):

Veterans Affairs Pension	$
Veterans Affairs Compensation	$
Veterans Affairs Aid & Attendance	$
Social Security or Railroad Retirement Benefits	$
Military Retirement	$
Civil Service Annuities and/or State Retirement Benefits	$
Company Retirement Pension(s)	$
Sale/Rent of Real Estate	$
Dividends/Interest/Annuities	$
Other	$

Please List:

Total $ 0.00

Spouse's Name:

I (for self or as financial legal representative for veteran) hereby declare that my total income and assets are as follows:

Per Month Incomes (Gross):

Veterans Affairs Pension	$
Veterans Affairs Compensation	$
Veterans Affairs Aid & Attendance	$
Social Security or Railroad Retirement Benefits	$
Military Retirement	$
Civil Service Annuities and/or State Retirement Benefits	$
Company Retirement Pension(s)	$
Sale/Rent of Real Estate	$
Dividends/Interest/Annuities	$
Other	$

Please List:

Total $ 0.00

Section II

Veteran Assets

Does Welfare, SSI, Medicare, or Medicaid pay any part for the patient's expenses? If so, how much _____

If Medicaid, when did coverage begin?_____

Do you own or have any interest in real estate?
[ ] Yes [ ] No Value $_____

Is this your homestead [ ] Yes [ ] No

Do you plan to return [ ] Yes [ ] No

Cash on hand $_____

Cash in Bank/Savings & Loan Institutions/Credit Unions:

Checking $_____

Savings/Certificate of Deposit:
$_____

Names & Addresses:
_____

_____

_____

IRA/s/Keough: $_____

Other Assets (Stocks/Bonds, etc.):
$_____

$_____

Do you have an interest in a trust fund?
[ ] Yes [ ] No

Life Insurance:
Face Value _____ Cash Value _____

Signature_____

Spouse Assets

Does Welfare, SSI, Medicare, or Medicaid pay any part for the patient's expenses? If so, how much _____

If Medicaid, when did coverage begin?_____

Do you own or have any interest in real estate?
[•] Yes [ ] No Value $_____

Is this your homestead [ ] Yes [ ] No

Do you plan to return [ ] Yes [ ] No

Cash on hand $_____

Cash in Bank/Savings & Loan Institutions/Credit Unions:

Checking $_____

Savings/Certificate of Deposit:
$_____

Names & Addresses:
_____

_____

_____

IRA/s/Keough $_____

Other Assets (Stocks/Bonds, etc.):
$_____

$_____

Do you have an interest in a trust fund?
[ ] Yes [ ] No

Life Insurance:
Face Value _____ Cash Value _____

Signature_____

Nevada State Veterans Home **Section III**

Authorization for Use or Disclosure of Medical Information

Name _____ Social Security number _____

1. **Explanation:** Pursuant to government codes and regulations, no copy fees may be charged. This authorization for use or disclosure of medical information is being requested of you to comply with the terms of NRS 449.705.

2. **Authorization:** I hereby authorize _____
(Name of physician, hospital, health care provider)
to furnish to Nevada State Veterans Home, medical records and information pertaining to my medical history, mental or physical conditions, services rendered or treatment **for the last two years, including all drug/alcohol and psychiatric/mental illness treatments.**

3. **Uses:** The requestor may use the medical records and type of information authorized only for the following purposes: **Application for admittance to the Nevada State Veterans Home.**

4. **Duration:** This authorization shall become effective immediately and shall remain in effect for 180 days.

5. **Withdrawal:** I understand that I may withdraw this authorization at any time by written request, however, any records released pursuant to this authorization prior to my withdrawal will not be affected by my withdrawal**.**

6. **Restrictions:** I understand that the requestor may not further use or disclose my medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law, or is to further my plan of care.

I understand that I have a right to receive a copy of this authorization upon my request.

Copy requested [ ] Yes [ ] No **Initials** _____

Print name: _____

Signature _____ **Date** _____

Signature of resident's representative _____
Spouse/financially responsible party *

If not signed by patient, indicate your relationship _____

* A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care served plan or an employee benefit plan.

A photocopy of this authorization will be considered as the original for release purposes.